MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10740 | 10740/94 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Howard — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D. C. — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville, Maryland — c. LENGTH OF STAY IN 1b: 118 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hinkson Nursing Home, R.F.D. # 2	d. STREET ADDRESS: 4753 Resevoir Rd., N. W., — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Katherine	Ann	Albert	October 10		1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		February 3, 1957		8	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minor Child		Paris, France	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis L. Albert, Jr.	Mary Swingle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	(Grandmother) Maude K. Swingle, 4753 Resevoir Rd., N.W., Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxoplasmosis - with internal — INTERVAL BETWEEN ONSET AND DEATH: 8 months

769.3

DUE TO (b) hydrocephalus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from July 1, 1957, to October 10, 1957, that I last saw the deceased alive on October 8, 1957, and that death occurred at 10:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker, M.D. — ADDRESS (Street, city or town, state): Clarksville, Maryland — DATE SIGNED: 10-10-57

PHYSICIAN'S NAME (Type): Charles S. Whitaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
CREMATION	10/11/57	FT. LINCOLN CREMATORY	PRINCE GEORGE CO., MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Warner E. Humphrey, SILVER SPRING, MD.	OCT 11 1957	Marie Whitaker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

CERTIFICATE OF DEATH

10741 Reg. Dist. No. 190

1. PLACE OF DEATH
a. COUNTY: Howard MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1935 Elkridge Heights ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Elkridge
d. STREET ADDRESS: 1935 Elkridge Hgts. ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NATHANIEL Middle J Last BENNETT

4. DATE OF DEATH: Month Oct Day 23 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 9, 1898
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): in Shop.
10b. KIND OF BUSINESS OR INDUSTRY: Sperry-Rand Inc
11. BIRTHPLACE (State or foreign country): South-port N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 108-05-2608
17. INFORMANT: Mrs Maurice Vermillion Address: 1935 Elkridge Hgts Elkridge 27 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion 1 hr
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Heart disease 3 yrs
DUE TO
(c): General arteriosclerosis 2 yrs

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 5, 1957, to Oct 23, 1957, that I last saw the deceased alive on Oct 22, 1957, and that death occurred at 8 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Brumbaugh M.D.
ADDRESS (Street, city or town, state): 7609 main St Elkridge 27 Md
DATE SIGNED: 10/23/57
PHYSICIAN'S NAME (Type): B B Brumbaugh

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Oct 24 1957
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn
22d. LOCATION (City, town, or county) (State): Elmira N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Henry W Jenkins & Sons Co 4905 York Rd
24a. REC'D BY REGISTRAR DATE: OCT 25 1957
24b. REGISTRAR'S SIGNATURE: H. Thad Hallinan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10742

CERTIFICATE OF DEATH

10742

Reg. Dist. No. 190

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
c. LENGTH OF STAY IN 1b: 6 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1944 Railroad ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Elkridge
d. STREET ADDRESS: 1944 Railroad ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Cleveland — Last: Chesgreen
4. DATE OF DEATH: Month: Oct — Day: 7 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr 28-86
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Harford Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. Chesgreen
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Hines

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-1699
17. INFORMANT: Mrs Catherine Frazier — Address: RFD #3 Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
163X
DUE TO
(b): Myocarditis & Decompensation — 1 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): General arteriosclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260X Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 29, 1922, to Oct 7, 1957, that I last saw the deceased alive on Oct 7, 1957, and that death occurred at 11 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Bruenbaugh M.D. — ADDRESS (Street, city or town, state): 3609 main st — DATE SIGNED: 10/8/57
PHYSICIAN'S NAME (Type): B B Bruenbaugh — Elkridge 27 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/10/57
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Park
22d. LOCATION (City, town, or county) (State): Davey Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — ADDRESS: Laurel Md.
24a. REC'D BY REGISTRAR DATE: OCT 11 1957
24b. REGISTRAR'S SIGNATURE: C Bird Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10743

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4
d. STREET ADDRESS: 4231 Green Mount Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Simon Rest Home

3. NAME OF DECEASED (Type or print): First: Miss — Middle: Mollie L. — Last: Clark

4. DATE OF DEATH: Month: October — Day: 26 — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 21, 1860

9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elkton, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. James F. Lewis, Address: 409 E. Cold Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — 10 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491x Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 1954, to October 26 1957, that I last saw the deceased alive on October 24 57, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker M.D.
ADDRESS (Street, city or town, state): Clarksville, Maryland
DATE SIGNED:

PHYSICIAN'S NAME (Type): Charles S. Whitaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/57
22c. NAME OF CEMETERY OR CREMATORY: Elkton, Cemetery
22d. LOCATION (City, town, or county) (State): Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Leonard J. Ruck 5305 Harford Road #14
24a. REC'D BY REGISTRAR DATE: OCT 30 1957
24b. REGISTRAR'S SIGNATURE: Marie Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10744

CERTIFICATE OF DEATH

10744 190
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Howard MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup.
c. LENGTH OF STAY IN 1b 4 yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Jessup.
e. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First BARBARA Middle ELIZABETH Last COLLIFLOWER

4. DATE OF DEATH Month Oct Day 18 Year 1957

5. SEX F
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Aug 24-1871
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Thurmont Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Freshman
14. MOTHER'S MAIDEN NAME Laura Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Address Norter Colliflower Jessup Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO (b) arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis
4200
INTERVAL BETWEEN ONSET AND DEATH 1 yr Onth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955, to 18 Oct, 1957, that I last saw the deceased alive on 15 Oct, 1957, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George E Grolean M.D.
ADDRESS (Street, city or town, state) main St Elkridge md
DATE SIGNED 18 Oct 57

PHYSICIAN'S NAME (Type) George E. Grolean Elkridge Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct 21-1957
22c. NAME OF CEMETERY OR CREMATORY W.B. Cem.
22d. LOCATION (City, town, or county) (State) Thurmont Md

23. FUNERAL DIRECTOR'S SIGNATURE Raymond E Cooper
ADDRESS Thurmont Md
24a. REC'D BY REGISTRAR DATE OCT 21 1957
24b. REGISTRAR'S SIGNATURE E. Bird Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10745 Item 7 FilmG221 10-18-57 et

10745 Reg. Dist. No. 174

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLIOAK RURAL
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: 3 Vol-4
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~1918 N Castle~~ Baltimore
d. STREET ADDRESS: 1718 N. Castle St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Speck Middle Ellison Last Faulkner
4. DATE OF DEATH: Month 10 Day 12 Year 1957

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-2-1907
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Falkner.
14. MOTHER'S MAIDEN NAME: Katie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 230-07-8651
17. INFORMANT: Janie Faulkner Address: 1718 N Castle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SHOTGUN WOUND of face and SKULL — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
919.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While hunting climbed over hog, Holding muzzel of 12 gauge shot gun which went off
20c. TIME OF INJURY: Hour 1 a. m. p. m. Month, Day, Year 10 12 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): farm-woods
20f. (City or town) ELLIOAK (County) Howard (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E Burgtorf M.D.
EXAMINER'S NAME (Type): GEORGE E. BURGTORF
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-12-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-16-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county) (State): Anne Arundel Ct. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles B. Lewis ADDRESS: 1639 W. Broadway
24a. REC'D BY REGISTRAR DATE: OCT 15 1957
24b. REGISTRAR'S SIGNATURE: Marie Mustaffa

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10746

CERTIFICATE OF DEATH

10746

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poplar Springs
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/ Poplar Springs
d. STREET ADDRESS: / R.D. Mt. Airy
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LAURA Middle ESTELLA Last FLEMING

4. DATE OF DEATH: Month October Day 28 Year 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 10-19-1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles D. Pickett
14. MOTHER'S MAIDEN NAME: Katherine Warthen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ------
17. INFORMANT: J.Elmer Fleming, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Generalized Arteriosclerosis	Several years
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Invalidism	9 years
(c)	Atrophic Arthritis	15 years
450.0		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 1955, to October, 1957, that I last saw the deceased alive on October 2, 1957, and that death occurred at 1 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D. ADDRESS (Street, city or town, state): Mt. Airy DATE SIGNED: 10/29/57

PHYSICIAN'S NAME (Type): W.B. Culwell Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-31-1957
22c. NAME OF CEMETERY OR CREMATORY: Poplar Springs
22d. LOCATION (City, town, or county) (State): Howard Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 31 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

10747 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HOWARD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR LAUREL
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LAUREL R.F.D

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Laurel R.F.D
d. STREET ADDRESS: No ST LAUREL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAN Middle H. Last HALL

4. DATE OF DEATH: Month OCT Day 28 Year 1957

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 12 1892

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: RACE TRACK

11. BIRTHPLACE (State or foreign country): HOWARD Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: MOSES HALL

14. MOTHER'S MAIDEN NAME: EMMA BOSTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 703-07-8[illegible]

17. INFORMANT: BERTHA HALL Address: LAUREL Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cor Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: Mo
345X
DUE TO
(b): Multiple sclerosis — 4 Mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 10, 19 57, to Oct 28, 19 57, that I last saw the deceased alive on Oct 28, 19 57, and that death occurred at 8 [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): Laurel Md DATE SIGNED

PHYSICIAN'S NAME (Type): N B Steward Laurel Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Oct 31 1957

22c. NAME OF CEMETERY OR CREMATORY: BEACON CHAPEL

22d. LOCATION (City, town, or county) (State): ANNAPOLIS Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgely Selby ADDRESS: 401 Washington Laurel Md

24a. REC'D BY REGISTRAR DATE: NOV 4 57

24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10748

CERTIFICATE OF DEATH

Reg. Dist. No. 10748

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dayton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Dayton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSALIE — Middle YVONNE — Last HARP

4. DATE OF DEATH: Month Oct. — Day 19 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 13, 1953

9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Olney, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harold Harp

14. MOTHER'S MAIDEN NAME: Pearl Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harold Harp, Dayton, Md — Address: /

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
758.6
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Albers-Schoenberg's Disease — 4 years ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/13, 1953, to 10/19, 1957, that I last saw the deceased alive on 10/19, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker M.D.
ADDRESS (Street, city or town, state): Clarksville, Maryland
DATE SIGNED: 10/19/57

PHYSICIAN'S NAME (Type): Charles S. Whitaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-22-57
22c. NAME OF CEMETERY OR CREMATORY: St. Marks
22d. LOCATION (City, town, or county) (State): Highland, Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: F. C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: 10-19-57

24b. REGISTRAR'S SIGNATURE: Maria A. Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

10749 CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH
a. COUNTY: HOWARD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JESSUPS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo JESSUPS, MD.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHRISTOPHER Middle C. Lost JOHNSON

4. DATE OF DEATH: Month OCT. Day 8th, Year 1957

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/8/1893

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PORTER

10b. KIND OF BUSINESS OR INDUSTRY: THEATER

11. BIRTHPLACE (State or foreign country): HALIFAX, N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ACKSON JOHNSON

14. MOTHER'S MAIDEN NAME: CRESA JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 213-10-5132

17. INFORMANT: NORA CLARETTA JOHNSON-JESSUPS, MD.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Prostate — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 19 55 to Oct. 8 19 57 that I last saw the deceased alive on Oct. 7 19 57 and that death occurred at 3.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E. Shipley M.D.
ADDRESS (Street, city or town, state): Savage Md.
DATE SIGNED: 10/10/57

PHYSICIAN'S NAME (Type): Frank E. Shipley M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/12/57
22c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEM.
22d. LOCATION (City, town, or county) (State): AA COUNTY, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Chas. H. Orpen
ADDRESS: 512 Cathedral Baltimore

24a. REC'D BY REGISTRAR DATE: 10/11/57
24b. REGISTRAR'S SIGNATURE: [illegible] E. Burl Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10750 (typed) 10750 (written) Reg. Dist. No. 191

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): B&O Railroad Track, depot yard

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City x2
d. STREET ADDRESS: Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: A. — Last: McKenzie
4. DATE OF DEATH: Month: 10/14 — Day — Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 24 1882
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Freeman
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Ellicott City, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Silas McKENZIE
14. MOTHER'S MAIDEN NAME: MARY M. DIZEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 208-09-0186
17. INFORMANT: John W. McKENZIE — Address: 116 W Vanmeter Bv Balto 10, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: instant
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E. Burgtorf M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): George E. Burgtorf — 10/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/17/57
22c. NAME OF CEMETERY OR CREMATORY: Good Shepherd
22d. LOCATION (City, town, or county) (State): Ellicott City Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F.C. Higinbotham Ellicott City Md
24a. REC'D BY REGISTRAR DATE: OCT 16 1957
24b. REGISTRAR'S SIGNATURE: H. Loughenane

1 (10)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10751

10751

CERTIFICATE OF DEATH

Reg. Dist. No. 190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Howard — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland. b. COUNTY: Howard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge — c. LENGTH OF STAY IN 1b: 3 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Elkridge
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Lawyers Hill, Elkridge	d. STREET ADDRESS: Old Lawyers Hill, Elkridge — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Levi	Middle: Daniel	Last: Mehring	4. DATE OF DEATH	Month: Oct.	Day: 13,	Year: 1957	
5. SEX: M.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Feb. 1, 1867	9. AGE (In years last birthday): 90 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Accountant	10b. KIND OF BUSINESS OR INDUSTRY: Franklin Trust Co.	11. BIRTHPLACE (State or foreign country): Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Tobias Mehring	14. MOTHER'S MAIDEN NAME: Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address: Old Lawyers Hill, Box #7	Mr. John Mehring, 14, Rt #4, Elkridge 27 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from Nov. 1955 to Oct 13 1957, that I last saw the deceased alive on Oct 3 1957, and that death occurred at 6:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. P. Von Schulz M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): A. P. Von Schulz, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Oct. 16/57	22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State): Littlestown Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE: OCT 16 1957	24b. REGISTRAR'S SIGNATURE: J. Burl Williams	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752

CERTIFICATE OF DEATH

10752 Reg. Dist. No. 194

1. PLACE OF DEATH
a. COUNTY: HOWARD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FULTON
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SIMONS REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 0210.2
d. STREET ADDRESS: Cedar Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle WILLIAM — Last MILLS.

4. DATE OF DEATH: Month OCT — Day 6 — Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 1, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: SELF RETIRED
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William M. Mills ~~UNKNOWN~~
14. MOTHER'S MAIDEN NAME: Sarah Carroll ~~UNKNOWN~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: MYRTLE A MILSTEAD — Address: HIGHLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Cardiac failure	3 hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary artery occlusion	3 hours
DUE TO (c)		

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/16, 1957, to 10/6, 1957, that I last saw the deceased alive on 10/6, 1957, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker, M.D. — ADDRESS (Street, city or town, state): Clarksville, Maryland — DATE SIGNED: 10/6/57

PHYSICIAN'S NAME (Type): Charles S. Whitaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/57
22c. NAME OF CEMETERY OR CREMATORY: Burtonsville Union Cem.
22d. LOCATION (City, town, or county) (State): Burtonsville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E Pumphrey — ADDRESS: Silver Spring Md.
24a. REC'D BY REGISTRAR DATE: OCT 8 1957
24b. REGISTRAR'S SIGNATURE: Marie Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10753

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10753

Reg. Dist. No. 19

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt. 32 East approach to Rt. 40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy 06x2.2
d. STREET ADDRESS: Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SANDRA — Middle RUSSELL — Last MORRISON

4. DATE OF DEATH: Month October — Day 15 — Year 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1938

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Grafton Dorsey

14. MOTHER'S MAIDEN NAME: Goldie Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -----

17. INFORMANT — Address: Mrs. Goldie Dorsey, Mt. Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Craniocerebral Injury.
983 x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Beat on head with auto jack handle.

20c. TIME OF INJURY: Hour 1:50 p.m. — Month, Day, Year 10/15 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public Highway

20f. (City or town) West Friendship (County) Howard (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 10/16/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-19-1957
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Fairview
22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz,
ADDRESS: Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 18 1957
24b. REGISTRAR'S SIGNATURE: Alice Hobbs

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10754

CERTIFICATE OF DEATH

10754 Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Ellicott City

c. LENGTH OF STAY IN 1b: 55 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Rural Ellicott City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Frederick Road Rt. 2

d. STREET ADDRESS: 1 Old Frederick Road Rt. 2

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LEE Middle DAVIS Last POMEROY

4. DATE OF DEATH: Month October Day 3 Year 1957.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: January 14, 1877.

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas Pomeroy

14. MOTHER'S MAIDEN NAME: Martha Larue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-12-0958

17. INFORMANT: Mrs. Mary E. Riddle Address: Rt. 2 Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

420.1

DUE TO (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Cardio-Vascular Disease — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 4, 1949 to Oct 3, 1957 that I last saw the deceased alive on August 10, 1957, and that death occurred at 7 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William F. Hassaway M.D. ADDRESS (Street, city or town, state): Ellicott City, Md DATE SIGNED: 10/3/57

PHYSICIAN'S NAME (Type): WILLIAM F. HASSAWAY M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/6/57.

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Howard County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Easton Sons Catonsville 28, Md

24a. REC'D BY REGISTRAR DATE: OCT 9 1957

24b. REGISTRAR'S SIGNATURE: H. Laughenour

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10755

CERTIFICATE OF DEATH

10755

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY ~~Balto.~~ Harford MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V 0 1 - 4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Nursing Home

d. STREET ADDRESS 3302 Devonshire

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last ROSEBERRY

4. DATE OF DEATH Month Oct. Day 3, Year 19 57

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov. 1, 1884

9. AGE (In years last birthday) 72 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10b. KIND OF BUSINESS OR INDUSTRY Fur Storage

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Roseberry

14. MOTHER'S MAIDEN NAME Cornelia Lloyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-1334

17. INFORMANT Address Mrs. Annette Roseberry - 3302 Devonshire

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH MINUTES

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c) Arteriosclerosis, generalized & Coronary Sever — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

Cerebral Thromboses, Recurrent, with psychosis

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-22, 1957, to 10-3, 1957, that I last saw the deceased alive on 10-3, 1957, and that death occurred at 12:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Irving J. Taylor M.D. ADDRESS (Street, city or town, state) TAYLOR MANOR HOSPITAL DATE SIGNED 10-3-57

PHYSICIAN'S NAME (Type) IRVING J. TAYLOR Ellicott City Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10/7/57

22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.

22d. LOCATION (City, town, or county) (State) Elkridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Balto 17 ADDRESS

24a. REC'D BY REGISTRAR DATE OCT 7 1957

24b. REGISTRAR'S SIGNATURE J. E. Loughrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

CERTIFICATE OF DEATH

10756

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City

c. LENGTH OF STAY IN 1b: 2 Yr 10 Mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffer Conv.Retreat

d. STREET ADDRESS: Montgomery Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Dorothy Middle: M. Lost: Ruppel

4. DATE OF DEATH: Month: Oct.16, Day: Year: 19 57

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan.22,1880

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.

10b. KIND OF BUSINESS OR INDUSTRY: O.H.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Neumann

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mr. Anthony J. Ruppel,3504 W.Franklin St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic CV disease — 10 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 56, to Oct 16, 19 57, that I last saw the deceased alive on Oct 15, 19 57, and that death occurred at 8:24 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Ellicott City

DATE SIGNED

PHYSICIAN'S NAME (Type): Dr L.A. Kaufman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.19/57

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery Balto.Md.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Witzke Funeral Dir.4101 Edmondson Ave

24a. REC'D BY REGISTRAR DATE: OCT 21 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10757

10757

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Shaffer's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Yo 4
d. STREET ADDRESS: 643 N. Augusta Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ella Middle Nora Last Schumacher

4. DATE OF DEATH: Month Oct. Day 28/57 Year 19

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 30, 1869
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wroten
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Norman Emmerich, 643 N. Augusta Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
443X
DUE TO (b): Hypertensive CV disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 57, to Oct 28, 19 57, that I last saw the deceased alive on Oct 27, 19 57, and that death occurred at 5:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Ellicott City Md DATE SIGNED: 11/30
PHYSICIAN'S NAME (Type): Dr. H. A. Kuchman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 31/57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Baltimore 29, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Fitzke Funeral Directors ADDRESS: 4101 Edmondson Ave.
24a. REC'D BY REGISTRAR DATE: NOV 1 1957
24b. REGISTRAR'S SIGNATURE: J. B. Laughran

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10758

10758

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Duvall Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Woodbine
d. STREET ADDRESS: Duvall Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY; Middle; Last SMITH

4. DATE OF DEATH: Month Oct. Day 31, Year 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: XXXXX? 1877

9. AGE (In years last birthday): 80 yrs. 2

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mary Smith, Woodbine, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: George E Burgtorf M.D.
EXAMINER'S NAME (Type): George E. Burgtorf
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: October 31, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: Nov. 5, 1957
22c. NAME OF CEMETERY OR CREMATORY: Bushy Park
22d. LOCATION (City, town, or county) (State): Cooksville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F.C. Higinbothom
ADDRESS: Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE: NOV 6 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10759

CERTIFICATE OF DEATH

10759

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffers Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Balto Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville Md 21228
d. STREET ADDRESS: 76 N Prospect Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ida — Middle: C — Last: Umstedt

4. DATE OF DEATH: Month: 10 — Day: 4 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/11/1877

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: August Umstedt

14. MOTHER'S MAIDEN NAME: ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Catherine M. Cancro — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic CV Disease	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Parkinson's Disease	5 yrs
DUE TO (c)	Tuberculosis - healed	30 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 002X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to Oct 4, 1957, that I last saw the deceased alive on Oct 4, 1957, and that death occurred at 2:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Ellicott City Md
DATE SIGNED: 10/5/57

PHYSICIAN'S NAME (Type): Dr. L. A. Tochman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/7/57
22c. NAME OF CEMETERY OR CREMATORY: Westlawn
22d. LOCATION (City, town, or county) (State): Baltimore City Md

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Mac Nabb & Son Catonsville

24a. REC'D BY REGISTRAR DATE: OCT 8 1957
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS